EXHIBIT B

TOMEI,SCOTT ALLEN
MREC - 0000420002 AGE/S - 50Y / M
DOB - 08/23/67
ADM - 10/26/17 DR - POLLOCK,CHRISTOPHE
ACCT - 1729902977

Check appropriate Facility:
☐FSRMC ☐MMC ☒PMC ☐LCMC ☐FLMC ☐ RMC ☐ MHHS
CH80850050 (7/13)

Communication Assessment and Right to Interpreter for Hearing Impaired

The information provided below will assist hospital staff and/or medical providers in communicating effectively with you during your visit to this facility, whether you are a patient, companion, or designated representative. All communication aids and services listed below are provided to you at the facility's expense and at no cost to you.

Date: 10/27/17 Reason for Hospital Admission/Visit: _____

Name: Scott Tomei

Nature of Impairment:
- X Deaf
- _____ Speech Impairment
- _____ Hard of Hearing
- _____ Other

Relationship to patient:
- X I am the patient
- _____ Designated Patient Representative
- _____ Companion
- _____ Other: _____
- _____ Family Member
- _____ Power of Attorney

If you are **NOT** the Patient, what is the Patient's name: _____

Please check any of the following which you believe would be helpful to communicate:
- _____ TTY/TDD
- _____ Written Communication
- _____ Exchange of Notes
- X Qualified Interpreter
- _____ Other: _____

Would you like to request the use of a qualified sign language interpreter during certain portions of the Hospital admission of the Patient?
- _____ No, I would not like to request the use of a qualified sign language interpreter.
- X Yes, I would like to request the use of a qualified interpreter using Deaf-Talk (where available), a video remote interpreting service that is available in the hospital 24-hours a day.
- X Yes, I would like to request the use of an on-site qualified interpreter, if one is available, needed, and my request will not delay the Patient's medical treatment.

Please check what services you will need in your room if you are admitted (Patient only):
- _____Telephone handset amplifier
- _____Telephone compatible with hearing aid
- _____Closed caption decoders for television set
- _____Other: _____
- _____Assistive Listening devices
- _____Flasher for incoming calls
- _____Paper and Pen for Writing

If your preferences change during your time at the facility, please notify a nurse and/or other hospital care giver.

X _____ 10/27/17
Patient/Companion/Designated Representative Signature — Date